EXHIBIT "G"

Ø 002/003

AETNA LIFE INSURANCE CO. NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY

1. 2. 3. 4. 5.	YOU MUST COMPLETE ALL BE SURE TO DATE AND SI EVENT, THE NAME, ADDRE DO NOT MAIL THIS CLAIM YOUR COMPLETED CLAIM EMPLOYER'S INSURANCE	BECOME SICK OR DISABLED WHIL M FORM DB 300 IF YOU BECOME S LITEMS OF PART A — THE "CLAIM IGN YOUR CLAIM (SEE ITEM 12). I SS AND REPRESENTATIVE'S RELA UNLESS YOUR HEALTH CARE PRO I SHOULD BE MAILED WITHIN TH	ICK OR DISABLED AF ANT'S STATEMENT". F YOU CANNOT SIGN JIONSHIP TO YOU SF IVIDER COMPLETES I IRTY (30) DAYS AFT	TER HAVIN BE ACCURA I THIS CLAIF IQULD BE N AND SIGNS TER YOU BI	G BEEN UNEMPLO NTE. CHECK ALL D M FORM, YOUR RI OTED UNDER THE PART R.—THE *H	DYEO MORE THAN FOUR (IATES, EPRESENYATIVE MAY SIC I SIGNATURE, FAI TH CAPE PROVINCED:	4) WEEKS. BN IT IN YOU	JR BEHALI	F. IN THAT
РΑ	RT A - CLAIMANT'S	STATEMENT (Pleape Prin	for Type) ANSIA	ED ALL	OHERTIONS			······································	·
1.	My name is MILI	AN A.	BAUZ	A. A.L.	M050110142	16161811	77 0	22	5 9
	First	10 - Middle	Lupt	Y /		Social	<u>ア (ゥー)</u> Security N	lumber	12 [7]
2.	Address (P V F) Number St	18 AL 111 E S-CA	Cliv or Toron	<u>puzgk</u>		<u> </u>	\$2.2		
3.	Tel. No. 845- 56	STATEMENT (Please Prin AU LEATINE Coa. 15-1152	4. Da	le of Birth	6.5.5	5 Married (Che	ok opol	API. NO	□ No
6.	My disability is (if injury,	also state <u>how, when,</u> and whe	g it occurred)			. N. project.	an unes	168	
7	l became disabled on	G 7 MonDs Day		2006		a. I worked on the	al day	 ∐ Yes	ID No
	b. I have since worked	l for wages of profit. ⊠ Yes	[] No If Yes	rox 8°. give da	tes				
				•					
<u>B.</u>	Give name of last empl	oyer. If more than one emplo	yer during the last	eight (B)	weeks, name a	il employers.			
		EMPLOYER'S			DATE OF EN	PLOYMENT	AVER	AGE WE WAGES	EKLY
	BUSINESS NAME	BUSINESS ADDRESS	TELEPHONE NO		FROM	THROUGH	_(include	e Bonuse	s, Tips,
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	V. 1 - V. 1 - V	Α		-					
9.	My job is or was	FAJF01/ SX	100 E V150E	I				*********	
			LOERY150R			Name of U	sion and Local	Number of	Apmbor
IV.	For the period of disabit a. Are you receiving wa	ity covered by this claim ages, salary or separation pay	r						
	A ULE AND INCRIMINATION	CRAMINIC.	, i						™ No.
	(1) Workers'. (2) Unemploy	compensation for work-conne yment insurance Benefits	cled disability	***********		,*12,,31,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u>[</u>	∐ Yes	☑No
									W No W No
	TE PVERTIE ALPANEA	moet ole reactal Social Sect	my wer for long-te	im disabil	шу	**********	,] Yes	[] No
	I have Treceived T	claimed from	A OK TOD, COMP	'LEIE IM	E FOLLOWING):			
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11.	i nave received disability	penetits for another period of	r periods of disabl	lity within	the 52 weeks in	nmediately before my	present d	sability t	egan-
	II "YES" fill in the following	ar I bara basa asid bu	###**###******************************	*******	**************	***************************************	*** ** * * * * * * * * * * * * * * * * *	Yes	M.No
	A CONTRACTOR OF THE PARTY OF TH	g: Thave been paid by		***************************************	realizate to the name parameter	From	То		le
12.	I have read the instruction	ons above. I hereby claim Dis	ability Benetits an	d certify th	at for the peco	d covered by this else	as Luman du	abied, a	nd that
ANY	PERSON WHO KNOWING	Y AND WITH INTENT TO DEED	DEPENDENCE CAPI	CCC TO DE	of my knowled	ge true and complete			
		BY AN INSURER, OR SELF-INS LTY OF A CRIME AND SUBJECT				FALSE MATERIAL STAT	EMENT OF	CONCE	LS ANY
	Claim signed on6	0-7-06	TO GOOD TAKE AN	YES AIVU JA	A A A	na Bar			
	If signed by other than of	aimant, print below: name, a	ddress, and relatio	onship of r	/Gamanra Signal epresentative	rty (3		4444
	Makeka (a series a s								
Disc	locure of information: The	Board will not disclose any info	mation about your	case to an	y unauthorized p	party without your cons	ent. If you	choose to	have
Worl	kers' Compensation Recor	ds, or an original signed, antari	rod anthodystical la	an ongma	i signea rorm O	C-11th, Clamant's Au	lhorization	to Disclos	
	or you may download it fro orization form or letter to th		l <u>o rry us</u> . It can be f	ound unde	r the heading Co	ommen Forms Online.	Mail the co	mpleted	on mac r
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WOR		WORKERS COMPENSATION SOAR RO. DISABILITY BENEFITS BUREAL		COMPENSA	NG COMUNIQUES!	nadas con la reclai E con la oficina mas Eueva York, o escriba a- E bureau, 100 eroadwa	CERCANA	DE LA JL	BO ATM
		HEALTH CARE DOC						ALDANT,N	12/41-

HEALTH CARE PROVIDER MUST COMPLETE PART B ON REVERSE

D8-450 (2-04) **EXHI**



NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

WITHIN FOUR (4) WEEKS AFTER TERMINATION O					TO THE STATE OF						
PART B — HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)											
THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN DAYS OF THE RECEIFT OF THE FORM, For Item 7d, give approximate date. Make some estimate, if											
disability is caused by or orising in connection with progn	ancy, enter calimated delive	niy dato undar "Remurku"	approxime care: i	HEND BOILD	potimais, it						
1. Claimant's Name MIRIAN BAUZ	<u>a </u>	2. Date of Birth 6	<u>5.54</u> 3.5		ale [[Female						
4. Diagnosis/Analysis Akast Cavecは		*	Diagnos	is Code_	174.1						
a. Claimant's Symptoms					\ \						
b. Objective Findings ANAONAA (AN	2 14 11	16 × C	<u> </u>								
3/41											
5. Claimant Hospitalized? ☐ Yes ☐ No	From <u>6.2.c.</u>		<u> </u>		V						
6. Operation Indicated?	a. Type <u>Crouz zo</u>	<u>FAC wast</u> b. Date <u> </u>	6-7-06		·						
7. Enter Dates for the Following:	•	\	Month	Day	Year						
 a. Date of your first treatment for this disability. b. Date of your most recent treatment for this disability. 			6	 Z	126_						
c. Date claimant was unable to work because of	•	•	- C	20)	06						
d. Date claimant will be able to perform usual w			9		0.40						
(Even if considerable question exists, estimate d	late. Avoid use of terms	such as unknown or undetermin			1 N = 174						
8 In your opinion, is this disability the result of injur			oational disease?	[]] Yes	i ⊟-No						
If "Yes", has form C-4 been filed with the Worker Remarks (attach additional sheet, if necessary)											
Temetre ferrant adamotic anest a recessor?	(If disability is prognancy related, phosic costs	(.alab yavava holismilaa								
Laffirm that Lam a Chiropractor				icense N							
Dentist Podi				<u>,۲^۲۲</u>							
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO	DEFRAUD PRESENTS, CAU	SES TO BE PRESENTED, OR PRES	PARES WITH KNOWL	EDGE OR E	SELIEF THAT IT						
WILL BE PRESENTED TO OR BY AN INSURER, OR SE MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SU	BJECT TO SUBSTANTIAL F	MES AND IMPRISONMENT.	MATERIAL STATEME	ENT ON L	UNCEALS ANT						
Health Care Provider's Signature 4/01000			-								
Hoalth Care Provider's Name (Please Print)	CX 42 DY C	GRD(Tel. No	<u> </u>	وسيتنكف						
Office Address 105 6 4 46 57	City or	Town	Sinte	1000							
HIPAA NOTICE - in citter to adjudicate a workers compensate	ion claim, WCL 13-a(4Va) an	H 12 NYCRR 325-1.3 require analle of	re providers to recutad	y illo medic	al reports of						
treatment with the Board and the carrier or employer. Pursuan	it to 45 CFR 184.512 these to	gally required modical reports are oxe	rapi from HIPAA's restr	ictions on di	isclosure of						
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